

**MEDICAL CERTIFICATION FOR MEDICAID LONG-TERM CARE SERVICES AND PATIENT TRANSFER FORM**

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**A. PATIENT INFORMATION**

Gender:  Male  Female  
 Hispanic Ethnicity:  Yes  No  
 Race:  White  Black  Other: \_\_\_\_\_  
 Language:  English  Other: \_\_\_\_\_

**B. SIGHT HEARING**

Normal  Impaired       Normal  Impaired  
 Blind       Deaf       Hearing Aid      L      R

**C. DECISION MAKING CAPACITY (PATIENT):**

Capable to make healthcare decisions      Requires a surrogate

**D. EMERGENCY CONTACT**

Name: \_\_\_\_\_ Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Phone: \_\_\_\_\_

**E. MEDICAL CONDITION / RECENT HOSPITAL STAY**

Primary Dx at discharge:  
 Reason for transfer (Brief Summary): \_\_\_\_\_

Surgical procedures performed during stay:  None

Other diagnoses: \_\_\_\_\_

**F. INFECTION CONTROL ISSUES**

PPD Status:    Positive    Negative    Not known  
 Screening date: \_\_\_\_\_

Associated Infections/resistant organisms: \_\_\_\_\_

- MRSA    Site: \_\_\_\_\_
- VRE    Site: \_\_\_\_\_
- ESBL    Site: \_\_\_\_\_
- MIDRO    Site: \_\_\_\_\_
- C-Diff    Site: \_\_\_\_\_
- Other:    Site: \_\_\_\_\_

Isolation Precautions:  None

- Contact     Droplet     Airborne

**G. PATIENT RISK ALERTS**

- None Known     Harm to self     Difficulty swallowing
- Elopement     Harm to others     Seizures
- Pressure Ulcers     Falls     Other: \_\_\_\_\_

**RESTRAINTS:**    Yes    No

Types: \_\_\_\_\_

Reasons for use: \_\_\_\_\_

**ALLERGIES:**    None Known    Yes, List below:

Latex Allergy:    Yes    No    Dye Allergy/Reaction:    Yes    No

**H. ADVANCE CARE PLANNING**

Please ATTACH any relevant documentation:

Advance Directive	Yes	No
Living Will	Yes	No
DO NOT Resuscitate (DNR)	Yes	No
DO NOT Intubate	Yes	No
DO NOT Hospitalize	Yes	No
No Artificial Feeding	Yes	No
Hospice	Yes	No

**I. TRANSFERRED FROM**

Facility Name: \_\_\_\_\_  
 Date: \_\_\_\_\_ Unit: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_  
 Discharge Nurse: \_\_\_\_\_  
 Admit Date: \_\_\_\_\_ Discharge Date: \_\_\_\_\_  
 Admit Time: \_\_\_\_\_ Discharge Time: \_\_\_\_\_

**J. TRANSFERRED TO**

Facility Name: \_\_\_\_\_  
 Address 1: \_\_\_\_\_  
 Address 2: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**K. PHYSICIAN CONTACTS**

Primary Care Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_  
 Hospitalist Name: \_\_\_\_\_  
 Phone: \_\_\_\_\_

**L. TIME SENSITIVE CONDITION SPECIFIC INFORMATION**

Medication due near time of transfer / list last time administered  
 Script sent for controlled substances (attached):    Yes    No

- Anticoagulants    Date: \_\_\_\_\_ Time: \_\_\_\_\_
- Antibiotics    Date: \_\_\_\_\_ Time: \_\_\_\_\_
- Insulin    Date: \_\_\_\_\_ Time: \_\_\_\_\_
- Other:    Date: \_\_\_\_\_ Time: \_\_\_\_\_

**Has CHF diagnosis:**    Yes    No

If yes; new/worsened CHF present on admission?  
    Yes    No

Last echocardiogram: Date: \_\_\_\_\_ LVEF    %

**On a proton pump inhibitor?**    Yes    No

If yes, was it for:  In-hospital prophylaxis and can be discontinued  
 Specific diagnosis:

On one or more antibiotics?    Yes    No

If yes, specify reason(s): \_\_\_\_\_

Any critical lab or diagnostic test pending at the time of discharge?    Yes    No

If yes, please list: \_\_\_\_\_

**M. PAIN ASSESSMENT:**

Pain Level (between 0 - 10): \_\_\_\_\_

Last administered: Date: \_\_\_\_\_ Time: \_\_\_\_\_

**N. FOLLOWING REPORTS ATTACHED**

- Physicians Orders       Treatment Orders
- Discharge Summary       Includes Wound Care
- Medication Reconciliation**       Lab reports
- Discharge Medication List       X-ray       EKG
- PASRR Forms       CT Scan       MRI
- Social and Behavioral History

ALL MEDICATIONS: (MAY ATTACH LIST)

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

**O. VITAL SIGNS**

Date: \_\_\_\_\_ Time Taken: \_\_\_\_\_  
 HT: \_\_\_\_\_ WT: \_\_\_\_\_  
 Temp: \_\_\_\_\_ BP: \_\_\_\_\_  
 HR: \_\_\_\_\_ RR: \_\_\_\_\_ SpO2: \_\_\_\_\_

**P. PATIENT HEALTH STATUS**

**Bladder:**  Continent  Incontinent  
 Ostomy  Catheter Type: \_\_\_\_\_ date inserted: \_\_\_\_\_  
 Foley Catheter: Yes No If yes, date inserted: \_\_\_\_\_  
**Indications for use:**  
 Urinary retention due to: \_\_\_\_\_  
 Monitoring intake and output  
 Skin Condition: \_\_\_\_\_  
 Other: \_\_\_\_\_  
**Attempt to remove catheter made in hospital?** Yes No  
 Date Removed: \_\_\_\_\_  
**Bowel:**  Continent  Incontinent  Ostomy  
 Date of Last BM: \_\_\_\_\_  
**Immunization status:**  
 Influenza: Yes No Date: \_\_\_\_\_  
 Pneumococcal: Yes No Date: \_\_\_\_\_

**Q. NUTRITION / HYDRATION**

Dietary Instructions: \_\_\_\_\_  
 Tube Feeding:  G-tube  J-tube  PEG  
 Insertion Date: \_\_\_\_\_  
 Supplements (type):  TPN  Other Supplements: \_\_\_\_\_  
 Eating:  Self  Assistance  Difficulty Swallowing

**R. TREATMENTS AND FREQUENCY**

PT - Frequency: \_\_\_\_\_  
 OT - Frequency: \_\_\_\_\_  
 Speech - Frequency: \_\_\_\_\_  
 Dialysis - Frequency: \_\_\_\_\_

**S. PHYSICAL FUNCTION**

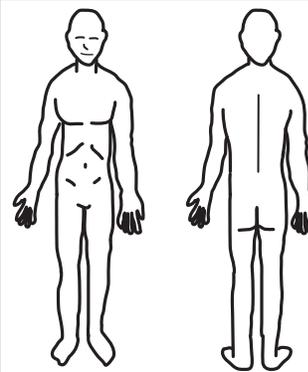
<b>Ambulation:</b> Not ambulatory Ambulates independently Ambulates with assistance Ambulates with assistive device	<b>Transfer:</b> Self Assistance 1 Assistant 2 Assistants
<b>Devices:</b> Wheelchair (type): Appliances: Prosthesis: Lifting Device:	<b>Weight-bearing:</b> Left: Full Partial None Right: Full Partial None

**Y. PHYSICIAN CERTIFICATION**

I certify the individual requires nursing facility (NF) services.  
 The individual received care for this condition during hospitalization.  
 I certify the individual is in need of Medicaid Waiver Services in lieu of nursing facility placement.

Effective date of medical condition _____	Rehab Potential (check one) <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor
Physician/ARNP Signature: _____	Date: _____
Printed Physician/ARNP Name & Title: _____	Phone Number: _____
Person completing form: _____	Phone Number: _____ Date: _____

**T. SKIN CARE – STAGE & ASSESSMENT**



Pressure Ulcers  
 (Indicate stage and location(s) of lesions using corresponding number:  
 1.  
 2.  
 3.  
 List any other lesions or wounds: \_\_\_\_\_

**U. MENTAL / COGNITIVE STATUS AT TRANSFER**

Alert, oriented, follows instructions  
 Alert, disoriented, but can follow simple instructions  
 Alert, disoriented, and cannot follow simple instructions  
 Not Alert

**V. TREATMENT DEVICES**

Heparin Lock - Date changed: \_\_\_\_\_  
 IV / PICC / Portacath Access - Date inserted: \_\_\_\_\_  
 Type: \_\_\_\_\_  
 Internal Cardiac Defibrillator  Pacemaker  
 Wound Vac  
 Other: \_\_\_\_\_  
 Respiratory - Delivery Device:  CPAP  BiPAP  
 Nebulizer  Other: \_\_\_\_\_  Nasal Cannula  
 Mask: Type \_\_\_\_\_  
 Oxygen - liters: \_\_\_\_\_%  PRN  Continuous  
 Trach Size: \_\_\_\_\_ Type: \_\_\_\_\_  
 Ventilator Settings: \_\_\_\_\_  
 Suction

**W. PERSONAL ITEMS**

Artificial Eye  Prosthetic  Walker  
 Contacts  Cane  Other  
 Eyeglasses  Crutches  
 Dentures  Hearing Aids  
 U  L  Partial  L  R

**X. COMMENTS (Optional)**

Signature: \_\_\_\_\_  
 Printed Name: \_\_\_\_\_